CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155291	A. BUII B. WIN			11/21/2	011
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0000 LABORATOR	State Licensure Sincluded the Investinct Investigation of the Investigat	099640: Unsubstantiated idence. 099871: Unsubstantiated idence. 090871: Unsubstantiated idence. 090888: 155291 00266310 NTeam Coordinator I. J. (11/14, 16, 17, 18, 21)		000	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZMTQ11

Facility ID:

000188 If continuation sheet

· ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER: 00			(X3) DATE SURVEY COMPLETED	
		155291	A. BUILDING B. WING			11/21/2	
			_	ET AD	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LEY FARMS RD		
EAGLE V	ALLEY MEADOWS	3	INDI	ANA	POLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
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	10111))						
	Sample: 20						
	Supplemental sar	mple: 3					
	These deficiencie	es reflect state findings					
	cited in accordan	ice with 410 IAC 16.2.					
	Quality review 1	1/30/11 by Suzanne					
	•	-, • •, · • • • • • • • • • • • • • • • • •					
F0253	The facility must p	rovide housekeeping and					
SS=D		-					
	•		F0253		F 253 Housekeeping and		12/16/2011
			1 0233		Maintenance Services It is the	ne	12/10/2011
					practice of this facility to prov		
					· -		
					sanitary, orderly and comfort		
					interior. What corrective		
	#97]						
						•	
	Findings include	:			deficient practice? The tower		
					were removed from the floor		
						J	
					created for resident #93 and	#97	
	-				that addresses the residents'		
	поиsекеерing/La	aunary Supervisor.			on the floor during toileting.		
	At 9:15 A.M. the	e bathroom of Resident			housekeeping and nursing st		
		t #97 had yellow soiled				s on	
		round the base of the			the floor by the Staff		
	toilet.				Development Coordinator on		
						nt	
	In an interview a	t 9:15 A.M., the			#93 and #97 were updated to		
	Quality review 1 Williams, RN The facility must p maintenance servi a sanitary, orderly Based on observa interview, the fac clean resident ba practice impacted reviewed for toild sample of 3. [Ref #97] Findings include Environmental to 11/16/2011 at 8:4 Maintenance Sup Housekeeping/La At 9:15 A.M. the #93 and Resident towels located ar toilet.	arovide housekeeping and dices necessary to maintain and comfortable interior. Action, record review and ceility failed to provide a throom. The deficient d 2 of 3 residents eting in a supplemental esident #93 and Resident.	F0253		practice of this facility to provide housekeeping and maintenar services necessary to maintal sanitary, orderly and comforts interior. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice? The towe were removed from the floor the bathroom for resident #9 and #97. A care plan was created for resident #93 and that addresses the residents' requests for towels to be place on the floor during toileting. housekeeping and nursing st were educated on infection control and not placing towels the floor by the Staff Development Coordinator on 12/08/11. The C.N.A. assignment sheets for reside	ide ince in a able ed insed i	12/16/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZMTQ11 Facility ID:

000188 If continuation sheet Page 2 of 20

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NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS STREET ADDRESS. CITY. STATE. ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214 REGULATORY OR IS DESCRIPTIVE OF DETECTION OF THE PROVIDER TRANSCUMBERTION OF THE PROVIDER TRANSCUMBERTION OF THE PROVIDER TRANSCUMBERT TO THE P	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	DING	00	COMPL	ETED
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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 11/21/2	LETED
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP CODI ALLEY FARMS RD APOLIS, IN46214	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE OPRIATE	(X5) COMPLETION DATE
	Assurance comm regarding the soi #93 and Residen document includ to, "November 7 Environmental T Resident #97] Re towels over the s	Four [Resident #93 and soom has toilet riser with seat, towels are soiled ants: Items mentioned		cleanliness, including the of soiled towels. How the corrective action(s) will monitored to ensure the deficient practice will note., what quality assurate program will be put into the Executive Director DNS will review the Dail check list daily to ensure bathrooms are clean and towels are on the floor. Bladder Program CQI to completed by DNS/design weekly for four weeks, for three months and quert two quarters unless three met. See attachment 2. Care Plan Updating CQI be completed by the MD Coordinator weekly for weeks, monthly times the months and quarterly the See attachment 3. Dai collected will be submitted CQI committee for review threshold of 90% is not a an action plan will be de Compliance date: 12/16	be be of recur, ince o place r and or y rounds the d no The of will be gnee monthly arterly for shold not The tool will S four ree ereafter. a ed to the w. If achieved, veloped.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/21/2011
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN46214	
(X4) ID PREFIX TAG F0279	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) the results of the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
SS=D	assessment to deveresident's compresent to deveresident's compresent to a care plan for each measurable object a resident's medic psychosocial needs comprehensive as the care plan must are to be furnished resident's highest mental, and psych required under §44 would otherwise be but are not provide exercise of rights or right to refuse treat Based on observative record review, the resident's toil deficient practice residents reviewed Plan in the supple [Resident #93 and Findings include Environmental to 11/16/2011 at 8:4 Maintenance Supplemental to 11/16/2011 at 8:4 M	velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and its that are identified in the sessment. St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). Aution, interview, and it is a facility failed to update eting Care Plan. The impacted 2 of 3 and for a toileting Care emental sample of 3. It is a facility failed to update eting Care emental sample of 3. It is a facility failed to update eting Care emental sample of 3. It is a facility failed to update eting Care emental sample of 3. It is a facility failed to update eting Care emental sample of 3. It is a facility failed to update eting Care emental sample of 3. It is a facility failed to update e	F0279	F 279 Develop Comprehens Care Plans A facility must us the results of assessments to develop, review, and revise t resident's comprehensive pla care. The facility must develo comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident medical, nursing, and mental psychosocial needs that are identified in the comprehensi assessment. The care plan in describe the services that are be furnished to attain or main the resident's highest practic physical, mental, and psychosocial well-being as required under 483.25; and a services that would otherwise required under 483.25 but ar	se o o o o o o o o o o o o o o o o o o o

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE	
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EAGLE \	ALLEY MEADOWS	3			ALLEY FARMS RD APOLIS, IN46214		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIL	DATE
	towels located as	round the base of the			provided due to the residen		
	toilet.				exercise of rights under 483	3.10,	
					including the right to refuse	(4)	
	In an interview a	at 9:15 A.M. the			treatment under 483.10 (b)		
					What corrective action(s) when the complished for those		
		aundry Supervisor			residents found to have be		
		esidents miss the toilet			affected by the deficient	, C11	
		re used to soak up the			practice? A care plan was		
	urine. He indica	ted the C.N.A.s are to			created for resident #93 and	d #97	
	change the towel	ls; however, not certain of			that addresses the resident	s'	
	how often the to	wels are to be changed.			requests for towels to be pla	aced	
					on the floor during toileting		
	In an interview a	nt 9:35 A.M., the			11/21/11. How will you ide	_	
		tor indicated the use of			other residents having the		
		e base of the toilet was			potential to be affected by		
					same deficient practice an what corrective action will		
		eek which resulted from			taken · All residents who u		
	a tour of the faci				toilet have the potential to b		
		nittee member. She			affected by this practice.		
	indicated staff w	ere instructed not to leave			team to review the care pla		
	soiled towels are	ound the base of toilet or			residents who use the toilet		
	on the toilet.				ensure accuracy by 12/16/1		
					What measures will be put	into	
	On 11/16/2011 a	at 2:00 P.M., Resident			place or what systemic		
		reviewed. No toileting			changes you will make to ensure that the deficient		
	care plan was no				practice does not recur · I	=ach	
	care plan was no	ited.			resident will be assessed fo		
	0 11/1/2011	10.15 D.16 D. 11			toileting program upon adm		
		at 2:15 P.M., Resident			annually and with significan	t	
		reviewed. No toileting			change · The MDS		
	care plan was no	ited.			Coordinator/designee will se	et up a	
					toileting program for those residents who are identified		
	The C.N.A. assig	gnment sheet, dated			through the assessment pro		
	11/16/2011, was	received on 11/16/2011			A toileting care plan will b		
	l '	om the Executive			implemented for residents	-	
		neet included, but was not			requiring a toileting program	ı. ·	
	limited to, Resid	· · · · · · · · · · · · · · · · · · ·			Toileting care plans will be		
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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULT A. BUILDI B. WING		00	(X3) DATE (COMPL 11/21/20	ETED
	DF PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	wheelchair as ne Extra large toilet comfort. No tow on toilet" Resi Mobility/Transfe wheelchair, may Needs: No towe floor of bathroom On 11/16/2011 a Executive Direct no title, with infe Assurance comm regarding the soi #93 and Resident document include to, "November 7 Environmental T Resident #97] Resident #97] Resident #97] Resident #97. Resident #97's C was not limited to 11/16/2011 Resident so not ollet so	ers: A 1 [Assist of one], use walker Special els around toilet seat or on m." It 1:20 P.M., the tor provided a document, ormation from the Quality mittee tour member led towels in Resident tr#97's bathroom. The ed, but was not limited and 8, 2011: Four [Resident #93 and from has toilet riser with seat, towels are soiled ints: Items mentioned quickly"			reviewed quarterly by the IDT team for accuracy. How the corrective action(s) will be monitored to ensure the deficient practice will not rei.e., what quality assurance program will be put into pla. The Bladder Program CQI will be completed by DNS/designee weekly for fouweeks, monthly for three monand quarterly for two quarters unless threshold not met. Seattachment 2. The Bowel Elimination CQI tool will be completed by DNS/designee weekly for four weeks, month for three months and quarter two quarters unless threshold met. See attachment 4. The Care Plan Updating CQI tool be completed by MDS Coordinator weekly for four weeks, monthly for three monand quarterly thereafter. See attachment 3. The Care Plan Review CQI tool will be completed by MDS Coordinator weekly for four weeks, month for three months and quarter thereafter. See attachment 5 Data collected will be submitt to the CQI committee for revilf threshold of 90% is not achieved, an action plan will developed. Compliance dat 12/16/11	ce tool Ir nths See Ally for d not ne will Inths, e an tor nly ly 5 ted ew.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291			(X2) MUL' A. BUILDI B. WING		OO	(X3) DATE S COMPLI 11/21/20	ETED
	ROVIDER OR SUPPLIER		;	3017 VAI	DDRESS, CITY, STATE, ZIP CODE LLEY FARMS RD POLIS, IN46214		
(X4) ID		FATEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Ē	COMPLETION DATE
	toilet with stool at the toilet Goal: not to use towels during toileting risks of using tow resident if towels. Resident #93's C was not limited to 11/21/2011 Retowels on toilet seed Resident has hist stool and urine of toilet Goal: Recomfortable on the will be encourage around toilet seed Approach: Explain	are Plan included, but o, "Problem start date: esident wishes to have eat and around the base. ory of soiling toilet with n the outside of the					
F0282 SS=D	facility must be pro	ided or arranged by the by ided by qualified persons an each resident's written					
	Based on record interview, the fac Plan of Care for a	review, observation and cility failed to follow the a non-slip surface on the on of a resident with a	F028	32	F 282 Services by Qualified Persons per Care plan The services provided or arrange the facility must be provided qualified persons in accordar	by	12/16/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZMTQ11 Facility ID:

000188

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
111,12112111	or condition.	155291	A. BUII			11/21/2	
		.00201	B. WIN		DDDDGG OWN GTATE THE CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ALLEY FARMS RD		
EAGLE \	ALLEY MEADOWS	5			APOLIS, IN46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	history of falls.	This impacted 1 of 9			with each resident's written p	lan	
	residents review	ed for falls in a sample of			of care. What corrective		
	20. (Resident #9	0)			action(s) will be accomplish		
	,				for those residents found to have been affected by the	,	
	Findings include	::			deficient practice? The dyce	em.	
					was replaced in the wheelch		
	The clinical reco	ord of Resident #90 was			resident # 90. The care plan		
		15/11 at 10:00 A.M.			resident #90 reflects the dyce	em in	
	137167734 011 117	10,11 41 10.00 11.111.			the wheelchair. The C.N.A. assignment sheet communic	atos	
	Diagnosas for D.	esident #90 included, but			need for dycem in the	aits	
		-			wheelchair. How will you		
		to, Alzheimer's disease,			identify other residents hav	ing	
	depression and h	nigh blood pressure.			the potential to be affected	_	
					the same deficient practice	and	
	_	nange Minimum Data Set			what corrective action will I		
	Assessment, date	ed 9/13/11, indicated			taken · All residents who ha	_	
	Resident #90 had	d long and short memory			dycem in the wheelchair hav potential to be affected by thi		
	problems and im	paired decision making			deficient practice. · IDT revie		
	skills.				all residents with dycem to e		
					that equipment was in place		
	An Interdisciplin	nary Team (IDT) note,			12/9/11. What measures wil		
	_	10:30 A.M., indicated			put into place or what syste	mic	
		fall: Res (resident) had a			changes you will make to ensure that the deficient		
		t 5:15 pm (sic). Prior to			practice does not recur?	The	
		ng in w/c (wheelchair) in			Checklist/Rounds will be		
		ed she started to back res			completed daily for each resi		
		and the res slid out of it.			by Department managers to		
		rward in w/c. Res was			ensure adaptive equipment is		
		o injuries noted. Room			place. See attachment 6. Ho		
	_				the corrective action(s) will monitored to ensure the	DE	
		time of fall. IDT agree			deficient practice will not re	cur.	
	_ · · · ·	m (a non-slip surface) to			i.e., what quality assurance		
	w/c, res is currer	nuy on tnerapy			program will be put into pla		
	caseload"				The ED/DNS will collect the		
					Checklist/Rounds tool daily to		
	A Fall Even, dat	ed 11/2/11, indicated			ensure completion. · The Fa	II	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPLI		
		155291	A. BUIL B. WIN			11/21/20	011
NAME OF F	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE LLLEY FARMS RD		
EAGLE \	ALLEY MEADOWS	3		INDIANA	APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	therapy was notineeds a dizem (so needs a dizem	fee was clutter in the room, fied and the wheelchair ic). falls, dated 9/20/11 and and 11/3/11, indicated darisk for falls related to mobility,, having a impaired vision, use of ing dependent on staff for of non-compliance and eness. Approaches re not limited to, Dycem cushion in w/c, 2 person fers and non-skid foot vation of Resident #90, on 5 A.M., she was resting elchair was setting beside as a Roho cushion in the nere was no dycem as			Management CQI tool will be completed by the DNS/desig weekly for four weeks, month for three months and quarter thereafter. See attachment 7 Data collected will be submit to the CQI committee for revilf threshold of 90% is not achieved, an action plan will developed. Compliance dat 12/16/11	nee nlly ly 7 ted ew.	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291		LDING	00	(X3) DATE COMPI 11/21/2	LETED
	PROVIDER OR SUPPLIER		•	3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0323 SS=E	environment rema hazards as is poss receives adequate devices to prevent A. Based on interest the facility failed supervision to a relopement from the practice impacted with a history of of 20 residents results. B. Based on obset the facility failed the locked demer practice had the practice ha	to provide adequate resident with a history of the facility. The deficient of 1 of 1 resident reviewed elopement from a sample eviewed. [Resident #6] ervation and interview, to secure a meat fork on the locked demential to impact 19 of the locked demential unit. Ord review, observation to efacility failed to the ement the Plan of Care of the locked the wheelchair the dent with a history of the 1 of 9 residents in a sample of 20.	F0	323	F 323 Free of Accident Hazards/Supervision/Devia The facility must ensure tha resident environment remai free of accident hazards as possible; and each resident receives adequate supervis and assistive devices to preaccidents. What corrective action(s) be accomplished for those residents found to have be affected by the deficient practice? On 10/11/11 an order was received to place resident # one to one observation twenty-four hours per day. The meat fork was removed the dementia unit on 11/16/ The dycem was replaced on w/c for resident # 90 on 11/ How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be tare. All residents who are at ri	t the ns as is ion event will een from 11. n the 16/11.	12/16/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 BUILDING 155291 11/21/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3017 VALLEY FARMS RD **EAGLE VALLEY MEADOWS** INDIANAPOLIS, IN46214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE elopement have the potential to be was not limited to, "Entity Reported affected by this deficient practice. Incident... Date of Alleged Event: All residents are assessed for 10/11/2011... [Resident #6] noted to be elopement risk upon admission, annually, and with significant change. sitting outside in patio... Continuous one IDT to review the elopement risk to one supervision..." and determine if security bracelets are needed. Security bracelets will be placed on those residents identified by On 11/14/2011 at 11:10 A.M., tour was IDT to be necessary. initiated with the Minimum Data Set Residents at risk will be added to the elopement book. Residents at coordinator [M.D.S.]. The M.D.S. risk will be noted on the C.N.A. coordinator indicated Resident #6 had a Assignment sheets. A care plan will be implemented history of behaviors requiring 1 on 1 for all residents who are at risk for supervision 24 hours per day and was not elopement. interviewable. Licensed professional staff will check for placement and function of the security bracelets every shift. Resident #6's record was reviewed on All residents on the dementia unit have the potential to be affected by 11/17/2011 at 1:25 P.M. Diagnoses this deficient practice. included, but were not limited to, All staff educated on progressive dementia, psychotic environmental safety by 12/16/11 by Staff Development Coordinator. See symptoms, depressed mood, and attachment 8. Alzheimer's disease. All residents with dycem have the potential to be affected. IDT reviewed all residents with Resident #6's elopement Care Plan dycem to ensure that equipment was in included, but was not limited to, "Problem place 12/9/11. start date: 6/01/2011, Resident at risk for What measures will be put into elopement due to: wandering to doors place or what systemic and holding down handle till door opens... changes you will make to Approach Start Date: 6/1/2011: ensure that the deficient Electronic monitoring bracelet placed on practice does not recur? wheelchair or ankle... Approach Start All exit doors have been secured Date: 7/11/2011: 1:1 supervision with with wanderguard alarms that will notify resident..." staff of residents attempting to exit 12/2/11 The Department head team was A Nurse's Progress Note dated 5/31/2011 educated on the Checklist/Rounds tool on 12/09/11 by the Executive Director. at 7:25 P.M. included, but was not limited

Facility ID:

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155291	A. BUI	LDING	00	11/21/2011
		133291	B. WIN			11/21/2011
NAME OF I	PROVIDER OR SUPPLIER				ALLEY FARMS RD	
EAGLE \	ALLEY MEADOWS	8			APOLIS, IN46214	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	THE CAMPAGNA WALLAND GOVERNMENT OF THE CAMPAGNA WAL	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	to, "Resident we	nt out B-Hall door			See attachment 9. The Checklist/Rounds will I	
	noted to be sittin	g in wheelchair outside			completed daily for each resident to	
	no apparent injur	·y"			Department Managers to ensure	
					adaptive equipment is in place and hazardous materials are removed.	
	A Nurse's Progre	ess Note dated 6/12/2011			attachment 6.	
	at 5:34 P.M. incl	uded, but was not limited			Usu the same stive setion/s	A .
	to, "Resident exi	ted through front door			How the corrective action(s will be monitored to ensure	·
	this a.m watch	every 15 minutes to			deficient practice will not re	
	make sure remain	ns in building"			i.e., what quality assurance	
					program will be put into pla	ce
	A Nurse's Progre	ess Note dated 7/4/2011 at			The Missing	
	2:40 P.M. includ	ed, but was not limited			 The Missing Resident/Elopement CQI too 	l to
	to, "Staff noted to	hat resident had opened			be completed by the	
	therapy door and	exited 15 minute			DNS/designee weekly for fou	
	checks started"	,			weeks, monthly for three mon	
					and quarterly for two quarters unless threshold not met. Se	
	An Interdisciplin	ary Team [IDT] Progress			attachment 10.	
	Note dated 10/10	0/2011 at 9:49 A.M.			· The ED/DNS will colle	ct the
	included, but wa	s not limited to,			Checklist/Rounds tool daily to	0
	"Resident had be	haviors on 10/8/11 and			ensure completion. The Fall Management	COL
	10/9/11 hitting	staff, yelling at staff,			tool will be completed by the	
	grabbing peers w	heelchairs, punching			DNS/designee weekly for fou	ır
	wall, tearful, and	exit seeking IDT in			weeks, monthly for three mon	
	agreement to cor	ntinue one on one			and quarterly thereafter. See attachment 7.	9
	[supervision]"				• Data collected will be	
					submitted to the CQI commit	
	A Nurse's Progre	ess Note dated 10/10/2011			for review. If threshold of 90	
	at 9:49 P.M. incl	uded, "Order obtained for			not achieved, an action plan be developed.	WIII
	wonderguard (sie	c) due to elopement			be developed.	
	risks."				Compliance date: 12/16/11	
	A Nurse's Progra	ess Note dated 10/11/2011				
	_	luded, but was not limited				
	io, "Kesident exi	ted the building, not				

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE (COMPL 11/21/20	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>		DDRESS, CITY, STATE, ZIP CODE		
	ALLEY MEADOWS				LLEY FARMS RD APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES	<u> </u>	ID I	AF OLIS, 114402 14		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	lE	DATE
		staff. Staff was doing 15					
		then it was noticed that					
		in visual sight. Staff					
	1 -	or the resident down the form. Staff noted resident					
	outside in back p						
	_	ing on to a side rail that					
	was along the wa						
	[wanderguard] d	id not sound Resident					
	safe inside with	staff doing one on one"					
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		der dated 10/8/2011					
	included, but wa	[one to one supervision]					
		15 minute checks when					
	asleep"	To minute encous when					
	A physician's ord	der dated 10/11/2011					
	included, but wa	•					
	"Discontinue pre						
		until evaluated by					
	psych"						
	Resident #6's Mi	inimum Data Set					
		nent, dated 10/28/2011,					
	included, but wa	s not limited to, "Brief					
	Interview for Me	ental Status [BIMS] 3					
		ent to mental status]					
		unit: limited assist, one					
	person physical	assist"					
	A document title	ed "Safety Check					
		s received from the					
	1	ing Services. The					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	CON	TE SURVEY MPLETED 1/2011
NAME OF F	PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE	
EAGLE V	ALLEY MEADOWS	3		7 VALLEY FARMS RD IANAPOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION DATE
	Resident #6 for t	ed hourly charting on he dates of 10/8/11 at gh 10/11/11 at 6:00 A.M.				
	P.M. with the Di Services, she ind nursing's "every Resident #6 were indicated there we minute charting;	on 11/21/2011 at 3:00 rector of Nursing licated charting regarding 15 minute" checks on e not available. She vas no policy regarding 15 however, she expected document 15 minute t sheets.				
	P.M., the Execut after the elopeme request was mad alarms on all fac only door with a the front entranc	on 11/21/2001 at 4:50 ive Director indicated ent on 10/11/2011, a work e to install wanderguard ility doors because the wanderguard alarm was e door. She indicated fast and could get out of				
	orientation tour of A.M., L.P.N. #2 residents residing Alzheimer's unit themselves througesident was mol	riew during the initial on 11/14/2011 at 11:08 indicated 18 of the 19 g on the secure/locked were able to walk by aghout the unit. One bile by using a was able to propel herself				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155291	B. WIN			11/21/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		3017 V	ALLEY FARMS RD		
	ALLEY MEADOWS			INDIAN	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	On 11/16/2011 a	•					
		our was initiated with the					
	Maintenance Su	-					
	Housekeeping/L	aundry Supervisor.					
	A+ 0.15 A M a	mont foul was absorved					
	1	meat fork was observed mentia unit kitchen					
		chen drawer was not					
	locked and did n	ot have a lock on it.					
	On 11/16/2011 a	nt 10:15 A.M., C.N.A. #3					
		l not know the meat fork					
	was in the kitche	en drawer and removed it.					
	C.1. The clinica	ll record of Resident #90					
		11/15/11 at 10:00 A.M.					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	Diagnoses for R	esident #90 included, but					
	were not limited	to, Alzheimer's disease,					
	depression and h	nigh blood pressure.					
	_	nange Minimum Data Set					
	· ·	ed 9/13/11, indicated					
		d long and short memory					
	^	paired decision making					
	skills.						
	An Interdisciplir	nary Team (IDT) note,					
	_	10:30 A.M., indicated					
		fall: Res (resident) had a					
		t 5:15 pm (sic). Prior to					
		ng in w/c (wheelchair) in					
		ed she started to back res					
		and the res slid out of it.					
	Kes does lean fo	rward in w/c. Res was					

000188

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•
EAGLE V	ALLEY MEADOWS	8		/ALLEY FARMS RD NAPOLIS, IN46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	fully dressed. No was cluttered at to (sic) to add dyce w/c, res is current caseload" A Fall Even, data Resident #90 had wheelchair. There therapy was not inneeds a dizem (so the control of the c	injuries noted. Room time of fall. IDT agree m (a non-slip surface) to atly on therapy ed 11/2/11, indicated d a fall from her re was clutter in the room, fied and the wheelchair ic). falls, dated 9/20/11 and and 11/3/11, indicated d a risk for falls related to mobility,, having a remainder of non-compliance and eness. Approaches re not limited to, Dycem recushion in w/c, 2 person fers and non-skid foot vation of Resident #90, on 5 A.M., she was resting elchair was setting beside as a Roho cushion in the nere was no dycem as	TAG	DEFICIENCY	
	_	iew with the Director of 6/11 at 11:30 A.M., she			

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 11/21/2011
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS RD IAPOLIS, IN46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0425 SS=D	and below on the that the wheelchanight before and been put back in 3.1-45(a)(1) 3.1-45(a)(2) The facility must peresidents, or obtain described in §483 facility may permit administer drugs it under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed phanic consultation on all pharmacy services Based on observatinterview, the fact appropriately dismedication. The impacted 1 of 1 mexpired medication.	rovide routine and and biologicals to its in them under an agreement (75(h)) of this part. The unlicensed personnel to its State law permits, but only supervision of a licensed vide pharmaceutical procedures that assure the procedures that assure the procedures that assure the procedures and biologicals to each resident. Imploy or obtain the services macist who provides aspects of the provision of in the facility. Action, record review and ceility failed to pose of an expired deficient practice resident reviewed with an on located in the facility's gerator in a supplemental	F0425	F425 Pharmaceutical SVC-Accur- Procedures The facility must provide routine and emergency drugs and biological to residents, or obtain them under and agreement described in 483.75 (h) this part. The facility may permit unlicensed personnel to administed drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceur	its of

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If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155291		LDING	00	11/21/2	
		100201	B. WIN	_	PRESIDENCE CONTROL CON	1 1/2 1/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			ALLEY FARMS RD		
EAGLE \	/ALLEY MEADOWS	5			APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	+	DATE
	on 11/17/2011 at Manager. At 9:3 medication, Aml 5 milliliters liqui of 7/21/2011. Thave been opene liquid left in the On 11/21/11 at 1 #84's record was included, but we dysphagia, respinexpressive aphas	ication room was initiated to 9:30 A.M. with the Unit 35 A.M., Resident #84's odipine 5 milligrams per 1d, had an expiration date the bottle was observed to d with a small amount of bottle. 1:00 A.M., Resident reviewed. Diagnoses re not limited to, ratory failure, anemia, sia, history or stroke, and			services (including procedures that assure the accurate acquiring, receiving, dispensing, and administ of all drugs and biologicals) to meet needs of each resident. The facility must employ or obtains services of a licensed pharmacist of provides consultation on all aspect the provision of pharmacy services the facility. What corrective action(s) where the accomplished for those residents found to have been affected by the deficient practice? The expired medication for resident #84 was disposed of according to facility policy on 11/17/11.	etering et the the who is of in iiii	
	record dated 10/2 and medication a dated 11/1/11 the the resident receive milligrams per 5 tube once daily a In an interview of A.M., the Unit Mexpected medical dates to be discard. A document title with a revised date	edication administration 1/11 through 10/21/11 administration record rough 11/30/11 indicated ived Amlodipine 5 milliliter per gastronomy at 6 A.M. on 11/17/2011 at 9:35 Manager indicated she tions with expiration reded. ed, "Expiration Dating" ate of 7/2011 from the			How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken and the same deficient practice and what corrective action will be taken and the same deficient practice does not expired meds were present on 11/17/11. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	ntial ctice. ure	
		and Procedure Manual,			All licensed staff were educated or handling expired meds by the Staff		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291 NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Was received from the Executive Director on 11/17/2011 at 10:50 A.M. The A. BUILDING 00 COMPLETED 11/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214 (X5) PREFIX (EACH CORRECTION GEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Development Coordinator by 12/16/11. See attachment 12.
NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Was received from the Executive Director STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214 (X5) PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEVELOPMENT COORDINATE DEVELOPMENT COORDINATE DEVELOPMENT COORDINATE DEVELOPMENT COORDINATE DEVELOPMENT COORDINATE DEVELOPMENT 12
NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS INDIANAPOLIS, IN46214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Was received from the Executive Director 3017 VALLEY FARMS RD INDIANAPOLIS, IN46214 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEVElopment Coordinator by 12/16/11. See attachment 12
EAGLE VALLEY MEADOWS INDIANAPOLIS, IN46214 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Was received from the Executive Director ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEVElopment Coordinator by 12/16/11. See attachment 12
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PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was received from the Executive Director PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DEFICIENCY) Development Coordinator by 12/16/11. See attachment 12
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1 00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
document included, but was not limited Pharmacy Services to audit medication
to "Durmoso." To angure integrity of carts and refrigerator every month.
medications Procedure: Medication
must be absolved by the facility regularly
for expiration dates and deterioration refrigerator every night for expired medications. See attachment 14.
Expired medications will be removed
form was and distanced. "
will be monitored to ensure the deficient practice will not recur,
In an interview on 11/21/2011 at 12:05 i.e., what quality assurance
P.M. with the Assistant Director of program will be put into place
Nursing [ADoN], she indicated the
Constitution of the second of
ractiffy's contract pharmacy checks all Review CQI tool will be medication on a monthly basis and not completed by DNS/designee
certain how this medication was missed certain how this medication was missed weekly for four weeks, monthly
times three menths and quarterly
since July 2011. She indicated a new for two quarters unless threshold bottle of medication was delivered on not met. See attachment 13
not met. See attachment 13.
11/17/2011 for Resident #84. Data collected will be submitted to the CQI committee
for any jour. If the ack ald of 000/ is
3.1-25(o) not achieved, an action plan will
be developed.
Compliance date: 12/16/11